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ABSTRACT

This practicum was performed to establish a model whereby a health planning organization, a hospital association, and a university can work together to meet the needs of each organization and the community. This model establishes a vehicle for learning experiences for physicians, trustees, and administrators in selected hospitals to assist them in the development of three-year operational plans required by Federal legislation. Significant health, social service, and higher education legislation passed since 1920 was reviewed to determine its primary and/or secondary impact on health manpower teaching programs in institutions of higher learning. This report recommends that the health planning organization, the hospital association, and the university collectively plan to meet identified community needs as they relate to comprehensive three-year operational organizational plans. Appendixes include the significant health and social service legislation passed by Congress since 1918 and significant higher education legislation enacted since 1920. (Author/MJK)

LEGISLATION DIRECTED TOWARD THE HEALTH DELIVERY SYSTEM: CAN IT HAVE A SECONDARY IMPACT ON HEALTH MANPOWER TEACHING INSTITUTIONS?

By

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A Practicum Presented to Nova University in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

Nova University

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Introduction

For nearly two hundred years, the Congress of the United States has passed legislation in response to or in anticipation of societal factors. This legislation is usually designed to meet the needs of most Americans or it may be directed toward different cultures or even individuals. The 1974 World Book Dictionary states that "an individual and a family are two different kinds of social units". It further states "that no political society can be, nor subsist without having in itself the power to preserve the property . . . of all that society." (John Locke)

Probably the most significant social legislation ennacted by the Congress of the United States was the passage of the Social Security Act on August 14, 1935. This Act had eleven separate Titles and has been ammended numerous times -- as recently as 1972. There are currently 19 Titles ranging from the provision of aid to dependent children to unemployment compensation and health insurance for the aged and disabled.

Clark Kerr provides an historical overview of education in the book titled New Teaching New Learning[1] and indicates that the university must extend service to the community and that education is a lifetime process.

This paper concerns itself with social factors, health and social services legislation and education. More specifically, it is concerned with the responsibility of Florida International University and its stated commitment to the health and social service organizations making up that body politic of the Greater Miami community.

The Greater Miami Community, for purposes of this paper, will be limited to the geographic boundaries of Dade County. Dade County had a March 1, 1974 estimated population of 1,418,000 persons[2]. The county extends along the Atlantic Ocean for

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[1] Smith, G. Kerry, Editor, New Teaching New Learning, Current Issues in Higher Education 1971, Jassey-Bass, 1971.

[2] Metropolitan Dade County Planning Department

60 miles and inland for about 30 miles. It is bisected by the Miami River which flows in a southeasterly direction toward the ocean. The major industries are tourism and the production of clothing.

The population is composed of about 25% Spanish-surnamed persons, 20% black and the balance is other.

The largest community college, Miami-Dade Community College, has four campuses located throughout the county. There are, in addition to the tax-supported Florida International University, four other institutions of higher educati on -- University of Miami, Barry College, Florida Memorial College and Biscayne College.

The health delivery system in Dade County was surveyed in 1969[3] to identify health delivery organizations, their service and staffing patterns and other pertinent characteristics. There were identified 217 organizations which were deliverying some component of health services. This figure does not include those organizations known solely as social service delivery organizations.

This report will concern itself with the role of Florida International University and the 36 short stay hospitals and their role to each other as they explore methods of responding to the dictates of Section 1122 of the 1972 Amendments to the Social Security Act. This section of the law states that organizations in receipt of Federal reimbursement for delivery of services must have three year operational plans which must be updated annually. This type of activity is not a usual pattern of operation for most health delivery organizations. Thus, this practicum will suggest a model whereby an educational institution can assist decision makers in short stay hospitals to develop a methodology whereby a viable planning process can be expected to occur in those participating delivery institutions.

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[3] The Health Planning Council of South Florida, Inc.

Background and Significance

Federal legislation is intended to serve as a vehicle whereby change is expected as the end result of the implementation of the elements addressed in the Act. Often the primary purpose will cause positive or adverse secondary effects on some other body politic other than was originally intended.

In this practicum, fifty years of Federally passed health, social services and education legislation will be reviewed to determine if there has been a significant amount of legislation directed toward the health industry which has had an indirect and subsequent direct impact on institutions of higher learning.

Noted below are two examples of legislation passed primarily for one purpose but which have had secondary effects which may prove more important in the long run than the original purpose for passing the legislation. The Health Professions Educational Assistance Amendments of 1965 (P.L. 89-290) extended and expanded the previous Act of 1963 by continuing for three years the program of matching grants for the construction of teaching facilities for selected health professions and also made loan monies available to students in these same professions. Although the primary intent of this legislation was to make construction and loan monies available to selected teaching facilities and students, the secondary and perhaps the more important potential effect this legislation had was to make more health professionals available to deliver health services.

Congress, in 1966, passed P.L. 98-749 which declared that "the fulfillment of our national purpose depends upon promoting and assuring the highest level of health attainable, for every person, in an environment which contributes positively to healthful individual and family living." Thus, this act's ultimate objectives were to promote the development of a healthful environment and a health care system in which quality health services would be available, accessible and affordable for

all persons. To carry out this charge, there was created State and areawide planning organizations with designated responsibility to assure that the intent of the legislation was carried out. Included as a part of this legislation were seed monies for institutions of higher learning to develop graduate programs to educate persons with the knowledge to enable them to perform as comprehensive health planners. Thus, in this case, we see that the primary intent of the legislation was to make health care the right of every American with a secondary benefit directed toward educational institutions of higher learning.

The recently passed 1972 Amendments to the Social Security Act provided in Section 1122, among other actions, that any health facility, in receipt of Federal monies rendered for services provided under the Medicare, Medicaid and Maternal and Child Health Programs, must have viable three-year operational plans. The rules and regulations spelled out in the Federal Registry state that administration, trustees and medical staff, if any, must assist in the preparation of this three-year comprehensive operational plan.

It is not unusual, even in urban communities, to find major health facilities which have not even designated an administrative person with planning responsibilities. Therefore, it is reasonable to assume that many, if not most, health facilities need to have made available to them educational opportunities to participate in learning experiences designed to provide their key decision makers (administrators, trustees and physicians) with the knowledge and skills necessary to carry out the intent of Section 1122 of the 1972 Amendments to the Social Security Act.

The purpose for performing this practicum is to affect a process whereby the South Florida Hospital Association, The Comprehensive Health Planning Council of South Florida and Florida International University can collectively work together to develop an educational program which will:

1. Make available learning experiences for persons in selected hospitals;

2. Encourage the development of three-year operational plans for the participating hospitals, and
3. Evolve a model for other communities to follow whereby a health planning organization, a delivery association and an educational institution can work together to meet the needs of each organization thereby fulfilling an even greater community need.

Procedure

The following procedures were performed in carrying out this practicum.

1. A search of United States Status at Large[4] from 1912 through 1941 were reviewed.
2. The United States Code[4], 1970 Edition was reviewed.
3. Congress and the Nation, 1945-1964, A Review of Government and Politics in the Postwar Years[4] was reviewed.
4. Laws Relating to Vocational Education and Agricultural Extension Work[4] was reviewed.
5. Compilation of the Social Security Laws[4] was reviewed.
6. Several other books, listed in References, were reviewed to determine significant societal factors effecting Federal legislation and to determine any effect the above legislation may have had upon institutions of higher learning.
7. Discussions were held with many colleagues concerning their views on the response of educational institutions to assist health delivery organizations meet Federal mandates imposed upon them.
8. The rules and regulations published in the Federal Registry dealing with the 1972 Amendments to the Social Security Act

[4]See references for more detail.

(Section 1122) were reviewed in light of their effect on health delivery organizations which were receiving Federal reimbursement for services provided.

9. The two documents[5] noted below were analyzed to determine the current status of the availability for learning experiences in selected disciplines.

10. Alternative solutions were designed as to how institutions for higher education could respond to the needs of health delivery organizations as noted in item eight above, were discussed with colleagues.

11. A suggested model for implementation was evolved.

12. The proposed practicum was distributed to three Nova peers for their review and comment.

13. The practicum was revised as suggested.

14. The practicum will be submitted to Nova University and to my colleagues in the participating organizations.

Results

The 21st Century has been one of continual change. In fact, the only constant has been change. In probably no other country has there been as much social change as in the United States. The ending of the 20th Centure signaled the demise of an agrarian economy and ushered in an industrial era. The aftermath of World War II encouraged the development of a service-oriented society.

Families at the turn of the century were known as "three generation" families. They often lived in the same household and usually in the same neighborhood or community as had their parents and grandparents. Eighty per cent of the population lived in rural areas. Today's family is referred to as the "nucleur family" with

[5] Allied Health Education Programs in Junior Colleges/1970 and Allied Health Education Programs in Senior Colleges/1971, compiled by American Association of Junior Colleges and the Association of Schools of Allied Health Professions. Both published by the U.S.D.H.E.W.

members extended outside the community, in different states and even different countries. Today more than 80 per cent of the population lives in metropolitan communities.

Major national happenings may be the causitive or perhaps the resultant force which stimulates persons to want change. Five major events stand out as significant indicators for bringing about social change and encouraging social policy planners to ply their skills. These events are World War I (1916-1918), the Great Depression (1930s), World War II (1941-1945), Korean Conflict (1950-1953) and the Vietnam War (1957-1973). These events were sufficient enough in magnitude to pressure Congress to enact legislation to diminish the causitive or resultant forces which brought about these five major national events and forced social change in our country.

The practice of medicine in the 1900s consisted of the physician and his nurse and he was the entry point into the health delivery system with the chronic care facility as his back-up resource. Today, the health delivery system is composed of more than 200 different kinds of professional and non-professional health and social service workers. The physician is no longer the only entry point into the health delivery system and there are a variety of organizations and facilities available for the delivery of health and social services.

Appendix A lists significant health and social services legislation passed by Congress since 1918. The Social Security Act of 1935 has been previously mentioned. It was probably the first major act which was passed by Congress responding to the need for social legislation in our country. The Federal government thereby assumed some responsibility for meeting the health and social needs of American which, because of their very nature, a single state was unable to effect since societal factors tend to cross geographic and political boundaries.

Congressional interest in effective health planning and resources development began with the enactment of the Hill-Burton (P.L. 79-733) program in 1946. This

program was designed to provide funds for the construction of needed new hospitals and other health facilities. It further contemplated that the states which received these funds would use them in accordance with demonstrated state-wide need based on an annual survey of existing facilities.

The Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89-749) authorized a two-year program of Federal support for comprehensive health planning and public health services. State planning agencies were required to be operational and areawide planning agencies were recommended and given a broad mandate to plan for all parts of the health system and any aspect of our physical, work or personal environment which affected health.

In 1972, the role of the state comprehensive health planning (CHP) agencies was strengthened by the Social Security Amendments of 1972 (P.L. 92-603). Section 1122 of this Act provides that health care facilities and health maintenance organizations (HMOs) would not be reimbursed by Medicare, Medicare or the Maternal and Child Health programs for depreciation, interest or return on equity capital relating to capital expenditures that were determined by designated state (CHP) agencies to be inconsistent with standards, criteria or plans developed by the state agencies. These same health delivery organizations were also required to have three-year operational plans which make provision for planned capital purchases, current and proposed changes in program and anticipated cash flow. Any change in program, purchase of equipment or capital construction costing more than $100,000.00 must have the ultimate approval of the Secretary of the Department of Health, Education and Welfare or his designee.

Proposed legislation (H.R. 16204 and S. 2994 :National Health Policy, Planning and Resources Development Act of 1974) will create throughout the country a new, strengthened and improved Federal, State and Areawide system of health planning and resources development.

The latter Act makes provision for a national council for health policy, designation of health service areas, health systems agencies, state health planning and development agencies, centers for health planning, revisions in the Hill-Burton program and area health services development funds. Therefore, the legislation is far-reaching and envisions that state and local communities can with the utilization of federal monies (creative federalism), plan effectively to meet the health and social service needs of its constituents.

In the Introduction of the Directory for Senior Colleges notes in footnote 5, it states: "...compiled this Directory of Allied Health Programs in senior colleges and universities in the United States as a first effort in developing a regular, comprehensive reporting system of education activities in the allied health field." One of the four stated purposes is to help administrators plan educational programs to meet community and national needs.

Table 1 shows selected administrative services programs in which health planning programs are usually located. The author has recently conducted a nationwide survey of some forty health management programs to determine the status of their planning and management curriculum. An article is now being edited by the second writer.

TABLE 1

Selected Administrative Services Educational Programs in Junior Colleges and Senior Colleges in the United States, 1970-71

Program	Junior College	Senior College
Health Administrative Assistant	7	-
Nursing Home Administrator	5	-
Health Planner	-	3
Health Services Administrator (Undergraduate)	-	8
Health Services Administrator (Graduate)	-	27
Health System Analysist	-	4
Hospital Unit Manager	-	3

It would appear that there is no unnecessary duplication of effort. However, personal communication has not proven this to be the case and the Association of Programs in Health Management is currently conducting a survey to validate this hypothesis. The study is also expected to result in the recommendation that programs coordinate their academic efforts.

These latter two documents do appear to be the first comprehensive nationwide effort to provide baseline data on selected health education program activities.

In the early 1900s medical schools were often proprietary institutions with no State or National accrediting body assuring some degree of quality of learning experiences. Pressures from within the profession were soon to assure that criteria were in existance to assure the American public that the profession was graduating only those persons capable of performing as independent practitioners.

The only other significant health teaching programs at the turn of the century were schools of nursing located in hospitals. These programs were of the apprentice type. Societal factors over the years have since caused most of these hospital based nursing programs to be phased out of existence. They have been replaced by two and four year programs in higher education institutions.

Other teaching programs were soon to develop as the aftermath of World War I not only returned many veterans with crippling injuries but also introduced new knowledge and techniques in the delivery of health services. Again, these teaching programs were usually located in proprietary schools or were based in hospitals.

The discovery of new health techniques and technologies and the creation and utilization of new kinds of personnel during and after World War II were sufficient to signal the development of an entirely new health delivery system in the United States. The Federal government made vast amounts of money available for the construction of new health facilities for demonstration projects designed to assure new methods of delivering health services. Both of the above resulted in the further

creation of newly recognized disciplines who were in need of common or similar academic experiences to better enable them to carry out their responsibilities.

Societal factors were sufficient in magnitude that educational institutions not only found it convenient but appropriate and satisfying to develop new teaching programs in the health disciplines. Their recognition of these factors encouraged educational organizations to seek funding from Congress enabling the educational institutions to construct classrooms and laboratories, employ faculty and often to make traineeships, scholarships or stipends available to students. Apprendix B cites major legislation, passed by Congress, intended to benefit the educational institutions with health teaching programs.

A casual survey of the two appendices shows that health and social services legislation directed to meet the health and social needs of the populace usually leads to other legislation directed to educational institutions to enable them to provide persons with the requisite knowledge and skills necessary to adequately provide the services spelled out in the earlier legislation. Note that the Nurse Training Act (1964), Health Professions Educational Assistance Amendments of 1965, Allied Health Professions Personnel Training Act of 1966 and subsequent manpower training acts followed the Hospital Survey and Construction Act (1946), the Research Institute Act of 1962 and the Mental Retardation and Mental Health Acts of 1963.

From the goals and facts noted above, it seems apparent that there exists a need for at least one institution of higher education in each major metropolitan community to plan for and make available new kinds of learning experiences that "...indicate that ideas and beliefs are formed on the basis of a complex pattern of interrelationships involving repetition, pleasurable as well as unwelcome stimuli, and inadvertant and incidental as well as more structured attempts to impart knowledge."[6]

[6]Political Education in The American Democracy, Cleary, Robert E., International Textbook Co., 1971, p. 114.

Recommendations

There are five alternative solutions which will be discussed in this paper. They will each be discussed in some detail and ranked in order of priority. The highest priority solution will be recommended for implementation and a plan spelled out to effect the implementation of this priority. Each of the latter four alternative solutions assumes that the individual health delivery organizations wish to meet the requirements of the legislation.

Alternative Solution #1

Alternative number one is a do nothing plan. That is, no organized effort would be put forward to assist the affected individual hospitals to meet the mandates of the Social Security Act of 1972, Section 1122. Each organization would be left to fend for itself as it strove to develop the essentials of a three-year operational plan.

Alternative Solution #2

This alternative solution calls for the Comprehensive Health Planning Council of South Florida to include in its scope of activities a vehicle whereby it would work with the individual hospitals to develop a planning program. This vehicle would, in essence, be a mechanism whereby a staff person would communicate and work with, on a regular basis, an individual(s) in the hospital to assist in the development of a three-year operational plan which would be designed to interface with the communitywide plan as evolved by the Council.

Alternative Solution #3

This alternative solution enlists the support and participation of the South Florida Hospital Association to implement. This organization represents more than 90 per cent of the hospitals in the five southern counties in South Florida. In this plan, the Association would be encouraged to seek and solicit the support of its members to evolve their three-year operational plans on an

organization basis to possibly dovetail with those of other hospitals serving a contiguous or an overlapping service area. This organization tends to speak for and preserve the integrity of each hospital and does so through a variety of programs: shared purchasing, health careers programs, leadership training programs and other mechanisms designed to enhance the general integrity of the Association and its member institutions.

Alternative Solution #4

This alternative solution concerns itself with the role of Florida International University and its responsibility and stated commitments to meet the educational needs of the community it serves. This solution calls for the University to develop curricula and to make it available to all potential students interested in learning more about the planning process in an academic setting. Thus, the University would unilaterally review the rules and regulations spelled out in the Federal Registry and develop a teaching program which it felt was best designed to meet the Federal requirements.

Alternative Solution #5

This solution is a combination of the latter three alternatives. It is intended to provide a mechanism whereby the Council, the Association and the University together plan a program of common learning experiences designed to meet the goals of each organization but also provide a vehicle whereby there will be developed mechanisms for the future implementation of needed teaching opportunities.

Recommendations

The above five alternatives are not listed in any specific order of priority. However, it is apparent that there is a sufficient enough need for health delivery organization personnel, especially hospital, to learn more about the planning

process so that they can develop viable three-year operational plans to meet not only their own needs but those of the community. Therefore, alternative solution number one is given the lowest priority.

Solutions two, three and four are all excellent solutions in their own right and a few years ago, each may have been implemented independent of each other and have met their own as well as some community need. However, delivery programs are now determined by identified community deficits and programs planned on the basis of free lines of communication encouraged by an organizational willingness to satisify those in need of assistance with the development of resources designed to meet community needs.

Therefore, it is recommended that the Council, the Association and the University collectively plan to meet the identified community needs as it relates to comprehensive three-year operational organizational plans. It is further recommended that this activity be carried out in the following manner.

Representatives from each organization should form a steering committee which would plan for the orderly development of a program designed to achieve a major two-fold purpose. The first purpose would be to develop an educational process whereby selected hospitals would participate in common learning experiences. The second purpose would be that each of these selected organizations would develop during this educational process a working draft of a three-year operational plan.

In addition to the above, the following steps should be pursued in implementing this educational learning experience:

-- An advisory committee should be developed to assist the three organizations achieve the above purpose. It is suggested that this advisory committee be composed of committed, concerned and knowledgable persons from the local community and like representatives from organizations such as the American Association of

Comprehensive Health Planners, the American Hospital Association, one or two other universities with health planning curricula and from other appropriate organizations.

-- This advisory body should give consideration to developing a curriculum to include in it the theory and principles of planning, description of health system, other delivery systems in the community, their relationship to other hospitals and to the community, financing health care, and other factors necessary to provide for an adequate preparatory learning experience in health planning.

-- A hospital should participate only if the same physician, trustee and administrator agree to participate in all sessions.

-- Sessions should last about three hours, be scheduled once per month, and the course should probably be eight to ten sessions in length in order to adequately meet the learning needs of the participants.

-- The classes should be held in a central Miami location, possibly in the conference of the Health Planning Council.

-- The services of an instructor from a health planning teaching program should be secured to teach this course.

-- Funding, in sufficient amount to cover the necessary expenses, should be sought from organizations known to have funded similar ideas in Miami and in other communities.

If the above specific recommendations can be implemented, it is important that all three organizations continuously evaluate this activity and, if appropriate, that plans be made to expand this experience to other health delivery organizations after completion of the first course.

The University should very carefully evaluate its role and participation in this community based performance oriented program. Its current academic health planning offerings may need to be expanded to provide on-going learning experiences for persons in need of these skills.

The successful implementation of this program will enhance the already fine community service programs in which Florida International University is participating.

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APPENDIX A

SIGNIFICANT HEALTH AND SOCIAL SERVICE LEGISLATION PASSED BY THE UNITED STATES CONGRESS, 1918-1972

1. "An Act to Provide for Vocational Rehabilitation and Return to Civilian Employment of Disabled Persons Discharged From the Military and Naval Forces of the United States", P.L. 65-178, June 27, 1918.

2. "An Act to Provide for the Promotion of Vocational Rehabilitation of Persons Disables in Industry or Otherwise and Their Return to Civilian Employment", P.L. 66-236, June 2, 1920.

3. "Social Security Act", P.L. 620-648, August 14, 1935

   Title I - Grants to States for Old Age Assistance
   Title II - Federal Old Age Benefits
   Title III- Grants to States for Unemployment Compensation Administration
   Title IV - Grants to States for Aid to Dependent Children
   Title V - Grants to States for Maternal and Child Welfare
   Title VI - Public Health Work
   Title VII- Social Security Board
   Title VIII-Taxes with Respect to Employment
   Title IX - Tax on Employers of Eight or More
   Title X - Grants to States for Aid to the Blind
   Title XI - General Provisions

   Titles XII through XIX Passed since 1935

   Title XII - Advances to State Unemployment Funds
   Title XIII - Reconversion Unemployment Benefits For Seaman (Provisions have expired)
   Title XIV - Grants to States for Aid to the Permanently and Totally Disabled
   Title XV - Accrued Leave, Unemployment Compensation for Government Organization and Employees (Later repealed)
   Title XVI - Grants to States for Aid to the Aged, Blind or Disabled, Or For Such Aid and Medical Assistance for the Aged
   Title XVI - Supplemental Security Income for the Aged, Blind and Disabled (Amended previous Title XVI)
   Title XVII - Grants For Planning Comprehensive Action to Combat Mental Retardation
   Title XVIII - Health Insurance for the Aged and Disabled
   Title XIX - Grants to States for Medical Assistance Programs

4. "National Cancer Institute Act", P.L. 74-77, Agusut 5, 1937.

5. "To Provide For The Training of Nurses For The Armed Forces, Governmental and Civilian Hospitals, Health Agencies", P.L. 78-74, June 15, 1943.

6. "An Act to Provide for the Promotion of Vocational Rehabilitation of Persons Disabled in Industry or Otherwise - Vocational Rehabilitation Act", P.L. 78-113, July 6, 1943.

7. "National School Lunch Act", P.L. 79-396, June 4, 1946.

8. "National Mental Health Act", P.L. 79-487, July 3, 1946.

9. "Hospital Survey and Construction Act", P.L. 79-733, August 14, 1946.

10. "To Amend the Public Health Service Act to Support Research and Training in Matters Relating to Arthritis and Rheumatism, Multiple Schlerosis, Cerebral Palsy, Epilepsy, Poliomyelitis, Blindness and Leprosy", P.L. 81-571, August 15, 1950.

11. "To Amend Public Health Service Act to Provide for the Establishment of an Institute of Child Health and Human Development, to Extend for Three Additional Years The Authorization for Grants for the Construction of Facilities For Research in the Sciences Related to Health", P.L. 87-838, October 17, 1962.

12. "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963", P.L. 87-167, October 13, 1963.

13. "An Act to Assist In Combating Heart Disease, Cancer, Stroke, and Related Diseases", P.L. 89-239, October 6, 1965.

14. "Comprehensive Health Planning and Public Health Services Amendments of 1966", P.L. 89-749, November 3, 1966.

15. "Occupational Safety and Health Act of 1970", P.L. 91-596, December 29, 1970.

16. "Social Security Amendments of 1972", P.L. 92-603, October 30, 1972.

APPENDIX B

SIGNIFICANT LEGISLATION PASSED BY THE UNITED STATES CONGRESS AFFECTING HIGHER EDUCATION HEALTH AND SOCIAL PROGRAMS 1920 TO PRESENT

1. "An Act to Authorize the Appointment of an Assistant Commissioner of Education in the Department of the Interior." P.L. 71-261, May 26, 1930.

2. "To Provide for the Further Development of Vocational Education in the Several States and Territories." P.L. 73-245, May 21, 1934.

3. To Provide for the Training of Nurses for the Armed Forces, Governmental and Civilian Hospitals, Health Agencies. P.L. 78-74, June 15, 1943.

4. "To Encourage Expansion of Teaching in the Education of Mentally Retarded Children Through Grants to Institutions of Higher Learning and to State Education Agencies." P.L. 85-926, September 6, 1958.

5. "To Amend the Public Health Service Act to authorize grants-in-aid to universities, hospitals, laboratories, and other public or nonprofit institutions to strengthen their programs of research and research training in sciences related to health." P.L. 86-798, September 15, 1960.

6. "Health Professions Educational Assistance Act of 1963." P.L. 88-129, September 24, 1963.

7. "Graduate Public Health Training Amendments of 1964." P.L. 88-497, August 27, 1964.

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10. "Medical Library Assistance Act of 1965." P.L. 89-291, October 22, 1965.

11. "Allied Health Professions Personnel Training Act of 1966." P.L. 89-751, November 3, 1966.

12. "Health Manpower Act of 1968." P.L. 90-490, August 16, 1968.

13. "Comprehensive Health Manpower Training Act of 1971." P.L. 92-157, November 18, 1971.

14. "Nurse Training Act of 1971." P.L. 92-158, November 18, 1971.

15. "Emergency Health Personnel Act Amendments of 1972." P.L. 92-585, October 27, 1972.